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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Diana Maria Prince, M.D.** **FMS** **5900 STATE FARM DR.** **ROHNERT PARK, CA 94928** **Physician's and Surgeon's Certificate No. A 63605,** Respondent.	Case No. 800-2017-035225 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 3, 1997, the Medical Board issued Physician's and Surgeon's Certificate Number A 63605 to Diana Maria Prince, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code provides, in pertinent part, that the Medical Board shall have responsibility for:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

" . . . "

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code, states, in relevant part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

". . ."

7. Section 2242(a) of the Code states that prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022[1] without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

BACKGROUND FACTS

8. At all times relevant to this matter, Respondent was a Family Practice Physician working at the Kaiser Permanente Medical Group.

9. Beginning in April 2009 and continuing to 2012, Respondent treated Patient P-1[2] for various medical complaints, including, primarily, chronic pain from degenerative lumbar disc disease, anxiety, depression and grief. Respondent initially performed a physical examination, and prescribed Carisoprodol[3], Oxybutynin Chloride[4], Morphine[5], Promethazine[6], and Hydrocodone-Acetaminophen[7]. Thereafter, Patient P-1 and Respondent communicated mostly by email or telephone call. Patient P-1 requested, and Respondent prescribed, potent opioids such as Percocet (also known as Endocet or Oxycodone-Acetaminophen)[8] for her breakthrough pain. Patient P-1 frequently requested early refills of medications.

10. By August 2009, Patient P-1 complained of anxiety and requested Xanax[9]. Although Respondent informed Patient P-1 that it is "very dangerous to mix with opiate pain medication

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[1] Dangerous drug means any drug unsafe for self-use in humans or animals including drugs that require a prescription to be lawfully dispensed.

[2] The patient is designated in this document as Patient P-1 to protect her privacy. Respondent knows the name of the patient and can confirm her identity through discovery.

[3] A muscle relaxant commonly used to treat muscle pain and discomfort.

[4] Ditropan is a trade name of this medication often used to treat bladder issues by decreasing muscle spasms.

[5] Morphine is an opioid analgesic and a dangerous drug as defined in section 4022 and a schedule II controlled substance. It is used for relief from moderate to severe pain.

[6] A medication often combined with narcotic pain medication after surgery to improve the effectiveness of the pain medication.

[7] Also known as hydrocodone bitartrate which is a semisynthetic narcotic analgesic and a dangerous drug as defined in section 4022 and a Schedule III controlled substance.

[8] Percocet and Endocet are trade names for Oxycodone and Acetaminophen combined. Oxycodone is an opioid pain medication sometimes called a narcotic and Acetaminophen is a less potent pain reliever that increases the effect of the oxycodone. Oxycodone is a dangerous drug as defined in section 4022 and a schedule II controlled substance. It is a more potent pain reliever than morphine or hydrocodone.

[9] Alprazolam is also commonly known by the trade name Xanax and is a benzodiazepine. It is a psychotropic drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance.

and I am not sure this is the best option", she nevertheless began to prescribe Xanax. Antidepressant medication was added, and over time, Patient P-1's life spiraled out of control as she lost her job and health insurance, and her husband died. Throughout 2009-2010, Respondent continued to prescribe large quantities of Xanax and Percocet, usually without seeing Patient P-1, and in spite of red flags such as requests for early refills and the patient acknowledging she was taking her medication in amounts greater than prescribed.

11. In an April 2010 email, Respondent noted to Patient P-1 that she was taking more than 5 Xanax per day and that Respondent was "completely terrified" by that, and that Respondent was "creating a person who is WAY overusing these medications." She further stated that "I am VERY uncomfortable with the Xanax use and am risking my medical license if we continue on this way." A subsequent email cautioned Patient P-1 that Xanax and Morphine were "a potentially dangerous combination". Respondent continued to prescribe these medications even after she learned that Patient P-1 had been psychiatrically committed.

12. By 2011, Respondent changed Patient P-1 from Xanax to Clonazepam[10] based on Patient P-1's telephonic assertion that Xanax was no longer effective. The prescribing pattern continued in spite of an April 2011 notification from a pharmacy questioning the prescriptions and early refills, and in spite of a documented notation that "[p]atient has clearly over used the medication due to her severe depression and anxiety around her bereavement, unemployment and near homelessness."

13. By August 2011, Respondent acquiesced to Patient P-1's request to switch from Oxycodone to the more potent Oxycontin[11].

14. On December 12, 2011, Patient P-1 called Respondent and stated she wanted to try Seroquel[12] again for sleep. Respondent prescribed Percocet and Seroquel along with

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[10] Clonazepam is a medication used to treat panic disorder and is a tranquilizer of the benzodiazepine class. It is a Schedule IV Controlled Substance and a dangerous drug as defined in section 4022.

[11] OxyContin is a trade name for oxycodone hydrochloride controlled-release tablets. Oxycodone is a dangerous drug as defined in section 4022 and a Schedule II Controlled Substance. It is a more potent pain reliever than morphine or hydrocodone.

[12] Seroquel is the trade name for Quetiapine and is an antipsychotic used to treat depression, schizophrenia and bipolar disorder.

Trazodone[13]. Eleven days later, Patient P-1 called and requested Zoloft[14] and Xanax which were prescribed along with Seroquel.

15. On February 29, 2012, Patient P-1 called and reported a "mental breakdown" and that she was having "falls due to back pain" and had some wounds forming from the falling. Respondent refilled her patient's medications including Trazodone 100 milligrams, Alprazolam (Xanax) 2 milligrams, Oxycodone-Acetaminophen (Percocet) 10/325 and Sertraline (Zoloft) 100 milligrams.

16. On March 26, 2012, Patient P-1 called Respondent to request an early refill of Xanax. Respondent complied and ordered the Xanax refilled early.

17. Respondent finally saw Patient P-1 one time on April 13, 2012. Respondent noted that her patient had "severe depression and chronic pain" and "is taking much more than prescribed dosage" of Xanax up to 8 per day "despite my warnings that this is too much for her". Respondent noted that the patient was positive for depression and suicidal ideas and negative for substance abuse. Nevertheless, Respondent continued prescribing controlled substances to Patient P-1 including Carisoprodol (Soma) 350 milligrams, Seroquel, Sertraline, Alprazolam (Xanax), Trazodone, Oxycodone-Acetaminophen (Percocet), and asthma medication.

18. On April 20, 2012, Patient P-1 called crying and in panic stating she was going through withdrawal, admitted to overuse and that was why she was running out early. The patient wanted more medicine as soon as possible and reported she was out of Percocet, Xanax and Soma. Respondent noted patient "really needs a psychiatrist" but had no resources to get one. The patient stated she had not slept for four days, was paranoid, had tremors, was hallucinating and seeing spiders when she goes outside. Respondent called in an early refill of Soma and Xanax and Zoloft.

19. On April 24, 2012, Patient P-1 called and said Hidden Valley Pharmacy would only give her one week of medication but that she had no car so very difficult to go back each week.

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[13] Trazodone is an antidepressant used to treat major depressive disorder and anxiety disorders.

[14] Zoloft is a Selective Serotonin Reuptake Inhibitor (SSRI) used to treat depression and post-traumatic stress disorders (PTSD).

The patient claimed again that a roommate took all the medications of a three-month refill. Respondent assisted patient in changing her pharmacy and sent additional prescriptions to the new pharmacy.

20. On May 2, 2012, Patient P-1 called and was "depressed and crying" and wanted to restart Wellbutrin[15]. Respondent told patient that she cannot give her more Xanax because she is already on "twice the recommended dose." Respondent prescribed 150 milligrams of Wellbutrin.

21. On May 11, 2012, Patient P-1 called "pretty agitated" and claimed having a panic attack and said she will run out of Trazodone tomorrow, needed to be able to increase Percocet to 8 per day and needed Xanax. Respondent refilled Percocet and Trazodone.

22. On June 15, 2012, Patient P-1 advised by telephone she had a new address. Respondent ordered Trazodone 150 milligrams and Percocet sent to her new pharmacy, Coyote Pharmacy. On June 20, 2012, Respondent refilled prescriptions for Soma, Trazodone, Zoloft, Wellbutrin and Xanax.

23. On June 22, 2012 Respondent spoke to Patient P-1 for the last time who said she had not received her Percocet. Respondent sent her patient a month of Hydrocodone-Acetaminophen (Norco) 10/325 and refilled the Soma, Trazodone, Zoloft, Wellbutrin and Xanax.

24. Patient P-1 was found dead on July 1, 2012 from "acute oxycodone toxicity." Patient P-1 had a combination of alcohol, benzodiazepines[16], carisoprodol and opioids[17] in her blood at the time of death.

CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence, Repeated Negligent Acts, Incompetence and Improper Prescribing Without an Appropriate Prior Examination and Medical Indication)

(Code Sections 2234(b),(c),(d) and 2242)

25. Respondent is subject to disciplinary action under section 2234, subdivisions (b) (gross negligence), (c) (repeated negligent acts), (d) (incompetence) and 2242 (improper

[15] Wellbutrin is a trade name for Bupropion which is used to treat depression.

[16] Benzodiazepines are commonly known as tranquilizers and are often used to treat anxiety.

[17] Opioids are narcotics, which block feelings of pain, and are often prescribed after surgery, severe injury or for chronic pain.

prescribing) of the Code in that Respondent has committed gross negligence and/or repeated negligent acts and/or incompetence and/or improper prescribing without an appropriate prior examination and medical indication in the practice of medicine as described above, including, but not limited to, the following:

A. Respondent failed to adequately take a medical history and conduct a physical examination for multiple medical problems including, but not limited to, chronic pain, anxiety and depression, while prescribing controlled substances. The circumstances are described below:

After initial visits with Patient P-1, most of Respondent's care of her patient was done by email or telephone, without a physical exam or personal encounter, including, but not limited to: ordering Xanax despite acknowledging it is "dangerous to mix with opiate pain medication"; refilling controlled substances including benzodiazepines and opioids; prescribing a new antidepressant to add to a current one; and refilling Percocet.

B. Respondent failed to create a clear treatment plan with objectives by which the treatment plan could be evaluated, such as pain relief and/or improved physical and psychosocial function. The circumstances are described below:

Respondent prescribed high doses of opioids and benzodiazepines without a clear treatment plan. Patient P-1's medical records show several examples of the necessity of a clear treatment plan including: dosage levels of Xanax being described as "not enough" by the patient; withdrawal symptoms occurring from lack of Xanax; evidence of overuse of medications; suicidal thoughts; early refills; and inadequate psychiatric follow up. And yet, Respondent created no corresponding treatment plan to include, for example, a tapering plan for medications, a referral plan to pain management, more frequent visits, or small prescription intervals.

C. Respondent failed to conduct periodic reviews of the course of treatment to include new information about the etiology of the pain or the patient's state of health. Respondent failed to evaluate progress toward treatment objectives despite continuing and modifying controlled substance prescriptions, adequate physical examinations or evaluations to continue the prescribed treatments that include combinations of controlled substances with a risk of overdose and death. The circumstances are described below:

During the course of treatment, Respondent failed to perform adequate examinations or evaluation of her patient in person. Respondent prescribed combinations of controlled substances with a risk of overdose and death. Respondent only conducted a handful of face-to-face visits with many refills of prescriptions, Respondent continued to prescribe controlled substances and changed them with no physical exam. She prescribed early refills and antibiotics without seeing the patient. By the time of the patient's final physical exam, patient was overusing her medications and had asked for many early refills.

D. Respondent failed to adequately monitor the patient's safety while on combinations of controlled substances with a risk of overdose and death. The circumstances are described below:

Respondent prescribed controlled substances without adequate monitoring and surveillance. Respondent did not closely monitor her patient who was on a combination of controlled substances, some of them in high doses, while the patient had uncontrolled symptoms. Respondent was aware of the dangerous possible interactions between opioids and benzodiazepines, yet she prescribed them without seeing the patient in person. Respondent repeatedly gave early refills despite no physical examinations, based on the patient's request and a variety of excuses that should have been red flags for medication abuse. Respondent continued to refill prescriptions without a tapering plan despite recognizing the need for tapering. Respondent acknowledged "risking (her) medical license" because of the high doses of Xanax she prescribed, and yet, Respondent prescribed even higher doses despite Patient P-1's promises to try to cut down. Respondent failed to refer her patient to the emergency room or to insist on a visit despite the patient complaining of withdrawal symptom, suffering from delirium tremens, and appearing to be in an altered state. Respondent prescribed a three-month supply of medications and prescribed Seroquel all at the patient's request when the patient stated that she had moved. Respondent continued to prescribe and change the combinations and doses of controlled substances, despite the patient not having health insurance through Kaiser, for over a year without a physical exam.

By the time Respondent saw her patient again after she obtained health insurance after a year and a half with no visits, her patient was overtaking benzodiazepines and was on a cocktail of medications that synergistically ran the risk of respiratory depression and death, including Xanax, Soma, Oxycodone, Trazodone and Seroquel. Respondent continued to prescribe these combinations of controlled substances despite her patient admitting to overusing, running out early and withdrawing from controlled substances. Respondent increased the doses at times without seeing her patient or referring her to the emergency room. Despite the patient's history of overuse of medications, Respondent appeared to increase her patient's Percocet less than two months before her death. Towards the end of Patient P-1's life, she ran out of Percocet so Respondent prescribed a month supply of Hydrocodone-Acetaminophen (Norco), but then a week later the Percocet was refilled at the pharmacy. Despite worrying about the high doses of Xanax and counseling her patient against increasing the dose of Xanax, Respondent still prescribed increasing doses. Respondent was concerned about patient's overuse of medications two years before her death, but continued to prescribe, at times, at increasing amounts despite prescribing more than the psychiatrist allowed. Despite acknowledging the risks and concerns related to overprescribing in combinations of drugs, Respondent did not adequately create a corresponding plan to address these concerns, such as tapering, referral to pain management, more frequent visits, or smaller prescription intervals.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 63605, issued to Diana Maria Prince, M.D.;

2. Revoking, suspending or denying approval of Diana Maria Prince, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Diana Maria Prince, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED:
November 20, 2018

KIMBERLY KIRCHMEYER
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State of California
Complainant

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Prince.diana.accusation